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The Trend of Divorce Since 1929

IN A previous issue of the STATISTICAL BULLETIN, it was shown that the marriage rate in this country gradually fell during the depression until, in 1932, it reached the lowest figure ever recorded for the country as a whole; also, that as business conditions improved, there was a marked increase in the number of weddings. Unfortunately, this same relationship is to be observed in the course of the divorce rate. Since divorce proceedings are expensive, it is not surprising that their number is greatly reduced during hard times or that returning prosperity brings with it a rising tide of divorces.

Owing to the fact that the United States Bureau of the Census ceased to publish marriage and divorce statistics after the year 1932, comprehensive figures for the entire country are not available for more recent years. To discover what has happened in the interval, it is necessary to have recourse to figures furnished by the 18 States* whose Health Departments collect data on divorces. These States, containing not quite one third of the total population of the United States, portray a situation so uniform that it is unlikely that they can be other than representative of conditions throughout the country.

During the years just preceding the depression (1926–1929), the divorce rate in these 18 States remained uniformly high. Following the crash of 1929, however, nearly every one of these States registered a sharp drop in the divorce rate, which continued to decline as the depression deepened. As in the case of the marriage rate, the lowest divorce figures were recorded in 1932, the year in which the business outlook was darkest. Also, duplicating the course of the marriage rate, a general increase in divorces began soon after the economic situation showed signs of improvement.

A steadily rising tendency since 1932 is discernible in each of the 18 States enumerated. Without a single exception, they reported higher divorce rates in 1935 than in 1932. During this period their aggregate rate rose from 121 divorces per 100,000 population in 1932 to 166 in 1935—an increase of 37 percent in three years. In a number of these States considerably larger increases

*Alabama, Connecticut, Florida, Indiana, Iowa, Maine, Maryland, Massachusetts, Michigan, Mississippi, Nebraska, New Hampshire, Oregon, Rhode Island, South Dakota, Vermont, Virginia, and Wisconsin.

were recorded: in Michigan the rise was about 41 percent; in Nebraska and in Wisconsin, 50 percent or more; in Florida, over 58 percent, and in Alabama, well above 68 percent. The smallest increases appeared in the New England States, where they ranged from 12 to less than 22 percent.

It is possible that in certain States for which figures are not yet available, contrary trends may have prevailed. But considering the general uniformity of the findings in the 18 States for which the figures are at hand, it seems hardly likely that such divergencies, if they exist at all, are anything more than exceptions to the general rule. The 18 States here discussed form a very fair cross-section of the country as a whole. They are so distributed that they represent all but three of the important geographic sections. The outstanding exception is the area covered by the Middle Atlantic States; the others are the West South Central and the Mountain States. Respecting the last named, it is especially to be regretted that we lack the figures for Nevada, since the divorce statistics of that State normally act as a barometer of the divorce situation throughout the country as a whole.

More liberal divorce legislation during recent years may possibly have accounted for a part of the rise in certain States. The facts are not at hand to permit an answer to this question, but this factor can hardly have exercised more than a negligible influence in any but a few States. The conclusion seems justified that the divorce rate is, like the marriage rate, closely bound up with business prosperity, both of them rising and falling in close conformity with economic conditions throughout the United States.

Deaths from Acute Accidental Poisonings

IN THE American home today are found many poison-containing compounds used as drugs, medicines, liniments, disinfectants, insecticides, cleaning fluids, and fuels. Many of these are labeled "poison"; many apparently are not known to a large number of people to be capable of killing when ingested. Ignorance of their contents or sheer carelessness in not storing them safely are responsible for the majority of the 1,400 deaths from poisons in the United States annually. About one third of these deaths from acute accidental poisonings occur among children under 5 years of age, and of these, nearly one half occur in the second year of life. Youngsters are just then beginning to toddle about and will put into their mouths whatever comes into their hands. A study of the death records of 298 persons insured in the Industrial Department of the Metropolitan Life Insurance Company who died of acute accidental poisoning during the years 1934–1935, reveals the circumstances surrounding these tragedies and suggests measures to pre-

vent them. Here, also, young children were found to be more frequent victims of accidental poisoning than were persons of any other age. Among the 298 deceased policyholders in this experience, 90 children were under age 5, 45 of them in the second year of life.

The manner of poisoning was given on 84 percent of the death records relating to these insured persons. All but a few may be roughly grouped into three classes: (*a*) Poisonous substances picked up and consumed by children, (*b*) poisons mistaken for medicines and overdoses of medicines, (*c*) ignorant use of substitutes for alcohol and fluids mistaken for alcoholic beverages.

Poisonous substances picked up and consumed by children were reported most frequently. There were 82 deaths of this type. Virtually all of these deaths may be charged, fairly, to the carelessness of parents in leaving pills and other poisonous agents within reach. Strychnine took the lives of 13 children. All but a few of the deaths of this character were caused by eating cathartic and tonic pills which seem to have a peculiar attraction for small children. Drinking kerosene caused 13 deaths. In addition to these there were seven deaths from gasoline, benzine, and other petroleum products. Lye, oil of wintergreen, hydrochloric and other acids, figure more or less prominently. Insecticides, rat poisons, and similar compounds containing phosphorous or arsenic, as well as undisclosed substances, caused many deaths of children.

Mistaking poisonous drugs for medicines or overdoses of medicines containing poisons accounted for 78 deaths. Veronal, luminal, allanol, and amytal lead the list with a total of 14 deaths; bichloride of mercury with nine deaths was next in order; lysol caused six deaths; arsenic, acetanilid, and paraldehyde, with four deaths each, were next in numerical importance.

Ignorant use of substitutes for ethyl alcohol was responsible for 30 deaths, most of which were due to ingesting wood or denatured alcohol. Fluids mistaken for alcohol were responsible for 13 additional deaths, five of which were due to drinking hydrochloric (muriatic) acid.

Food prepared with insecticides or other poisonous compounds mistaken for innocuous ingredients, and poisonous liquids mistaken for water caused several deaths.

There is an encouraging aspect to this otherwise gruesome situation. The death rate from these acute accidental poisonings among Industrial policyholders of the Metropolitan Life Insurance Company in 1935 was less than half of that registered in 1911. The trend of the death rate in recent years, furthermore, has been downward. Unfortunately, we do not have a complete series covering the earlier years showing the types of poisons involved nor the manner of poisoning. Comparison of the findings of the present study with a similar one for the years 1929 and 1930, however, shows relatively fewer deaths in the later period from most of the numerically more im-

portant poisons. There were many less deaths from drinking substitutes for ethyl alcohol or substances mistaken for it, from bichloride of mercury, strychnine, arsenic, lysol, and carbolic acid. Improvement in the labeling of poison-containing compounds, and a better understanding by the population generally of the dangers they face in using such substances, have probably brought about this improvement. But the number of deaths is still far too high. There is need to intensify the campaign. Education of the general public apparently, should be stressed most. Such educational activities should be made a part of the program of the many home safety crusades now being carried on all over the United States.

More care in the handling and storage of poisonous materials cannot be emphasized too strongly. These compounds, if they must be kept about the house, should be stored in places not easily accessible, and certainly well out of the reach of children.

The Company recommends built-in cabinets, preferably locked, to provide for the safekeeping of family medicines and drugs. To avoid mistakes or improper use, however, it usually is desirable to indicate these poisons by specially shaped containers, or bottles with luminous markings. A pin stuck in the cork of every bottle containing a poisonous substance also serves to indicate, in the dark, the nature of the contents.

Recent Decline in Appendicitis Death Rate

THE rising tide of deaths from appendicitis has finally been stemmed. In the past five years the standardized death rate from this cause among Metropolitan Industrial policyholders, ages 1 to 74, has dropped steadily from 14.3 per 100,000 in 1931, to 11.5 in 1935, a decrease of 20 percent. Among white male policyholders the rate last year, 13.5 per 100,000, was the lowest recorded in this group since 1919; particularly significant is the fact that white females in 1935 registered their lowest rate in a quarter of a century. Comparable data for the general population, available only to 1934, show the same general downward tendency.

Provisional figures for the first seven months of the current year point to the conclusion that the appendicitis death rate for the insured group as a whole will drop to even a lower level in 1936 than in the preceding year.

What factors have been at work to effect this recent improvement in mortality? This is a question of considerable current interest in the medical and public health fields, as is evidenced by the prominence given the subject in the periodical medical literature and at the medical society meetings throughout the country. Until very recently physicians have been stirred by the paradox of a decreasing operative mor-

tality and a rising total appendicitis death rate. Whatever were the forces acting to raise the death rate for at least two decades beginning with 1911, it appears that now the trend of the mortality from this disease is definitely downward.

The lessened toll of deaths from appendicitis in recent years may be attributed, we believe, in part to the widespread educational campaign conducted through the cooperation of public health officials, medical associations, insurance companies, retail druggists, school officials, and civic organizations. The educational attack against the excessive mortality from the disease has been centered on two factors which, obviously, were responsible for many deaths: The use of laxatives in the presence of abdominal pain, and the delay in hospitalization. The excellent statistical studies made by the health authorities in Philadelphia showed that, in recent years, only one in 64 of the appendicitis patients who had not received laxatives died; of those who had received one laxative, one in 18 died; and of those who received more than one, one in 11 died. Similarly, the mortality of cases admitted to the hospitals 48 to 72 hours after the onset of the attack was about three times that for cases admitted within 24 hours; where 72 hours or more had elapsed, the death toll was four times that for patients who reached a hospital within 24 hours. In this connection, it is of interest to recall that in the STATISTICAL BULLETIN of June 1935 we showed that in general the appendicitis death rate is highest where the hospital facilities are least adequate and least accessible.

Undoubtedly, the recent educational campaign has succeeded in bringing a larger proportion of appendicitis patients to hospitals earlier in the course of the disease and not handicapped by self-treatment with purgatives. Clinically, this means fewer cases complicated by peritonitis, and a decrease in the hazard of surgical intervention. This is just another illustration of the fact that an enlightened lay public is an invaluable ally to the public health and medical authorities in their common fight against death.

Certainly the medical profession has made its contribution to the recent reduction in the appendicitis death toll. Everywhere physicians and surgeons have been critically analyzing their experience, and these investigations have undoubtedly led to improved practices. From the current literature it is clear that the disease is being recognized more and more readily; that surgical skill and judgment have reached higher levels, especially in the treatment of spreading peritonitis; that the types of anesthesia being used are resulting in a more favorable experience, and that preoperative and postoperative care have been improved.

The table on page 6 shows that the decline in mortality occurred throughout the greater part of life. Only at the preschool years and at the older ages were increases in the death rate recorded. It may be, however, that the rises in mortality

at these ages are more apparent than real. It is at these periods of life that appendicitis is not as readily diagnosed as at other ages, and with an improvement in diagnosis it is to be expected that an increasing number of deaths will be certified as due to this disease. It has been suggested, however, that the diets of children nowadays may be the cause of an increase in the incidence of appendicitis in early childhood. Unfortunately, statistical data to substantiate or to refute this assertion are not available.

Appendicitis in the United States is still responsible for more than 18,000 deaths a year. Moreover, it ranks among the leading causes of death in childhood, adolescence, and early adult life. The conclusion is inescapable that many of these lives are needlessly lost. The tragedy of this loss is heightened by the fact that many of those who succumb to the disease are in the most productive period of life. Now that the paradox of the appendicitis mortality appears to be solved, the time is ripe for a nationwide and vigorous campaign to reduce this disease to a negligible cause of death.

Appendicitis Death Rates per 100,000 White Persons. By Sex and Age. Ages 1 to 74 Years. Metropolitan Life Insurance Company, Industrial Department. 1931 to 1935 and 1926 to 1930.

Age Period Years	Death Rates per 100,000				Percent Change 1931–1935 Since 1926–1930	
	White Males		White Females			
	1931 to 1935	1926 to 1930	1931 to 1935	1926 to 1930	White Males	White Females
1 to 74*.....	15.5	16.1	10.7	11.9	— 3.7	—10.1
1 to 4.....	12.7	12.1	10.7	9.7	+ 5.0	+10.3
5 to 9.....	11.5	12.1	11.1	12.2	— 5.0	— 9.0
10 to 14.....	14.0	14.0	9.1	11.2	.....	—18.7
15 to 19.....	15.3	17.7	9.2	10.8	—13.6	—14.8
20 to 24.....	13.6	16.6	7.2	9.7	—18.1	—25.8
25 to 34.....	13.6	14.9	8.3	9.7	— 8.7	—14.4
35 to 44.....	16.5	17.3	9.9	12.0	— 4.6	—17.5
45 to 54.....	20.6	20.9	14.5	15.5	— 1.4	— 6.5
55 to 64.....	22.2	20.8	18.6	17.9	+ 6.7	+ 3.9
65 to 74.....	27.1	20.3	19.0	17.4	+33.5	+ 9.2

*Standardized for age.

The Distribution of Physicians in the United States

In proportion to the total population, there are fewer physicians practicing in the United States, today, than there were 20 years ago, although in actual numbers there are now about 20,000 more legally qualified physicians in the country than were registered in 1916. In that year

there was one physician for every 694 persons in the entire population; in 1936 there was one doctor for every 778 persons.

The table on page 8, based upon figures abstracted from the Fourteenth Edition of the AMERICAN MEDICAL DIRECTORY, 1936, supplies a number of interesting facts. In the first place, it shows that the proportion of physicians to population steadily decreased up to 1929, when there was one doctor to every 797 inhabitants. Since then there has been a steady increase in the ratio of licensed physicians. This statement applies, particularly, with minor variations, to the industrial States of the Northeast and to most of the Mountain and Pacific Coast States. Apparently, the diminished opportunities offered by the business world in recent years have caused a larger proportion of medical graduates to go into actual practice than was customary during the boom years following the World War, when a considerable number of graduate physicians were attracted into industrial and other fields where their medical training could be better capitalized. At least, this seems to be true, in general, of the large centers of population.

Medical practice in the rural sections, as a rule, still has little or no attraction for the newly graduated medical student. This is evidenced by the fact that in such States as Mississippi, Alabama, Georgia, North and South Carolina, and the Dakotas, where from 70 to 85 percent of the inhabitants reside in the rural areas, the number of persons per physician ranges from 1,196 in South Dakota to 1,541 in South Carolina. On the other hand, in the States of Rhode Island, Massachusetts, New York, Illinois, and California, where the rural inhabitants constitute less than 27 percent of the total population, the ratio of persons to physicians ranges from 519 in California to 737 in Rhode Island. In other words, the average physician in South Carolina has nearly three times as many prospective patients in his locality as has a doctor in California or New York.

The drift of doctors to the large medical centers is further revealed in a study of the ratio of persons to physicians in certain of the leading cities of the country. In the Borough of Manhattan, New York, for example, there are only 287 persons per physician; in Boston there were 290; in Washington, D. C., 297; in San Francisco, 345; and in Los Angeles, 384.

Probably the smallest ratio of population per physician is to be found in Rochester, Minn., the home of the famous MAYO CLINIC, where one out of every 57 inhabitants is a physician or surgeon. Of course, the population actually served by these Rochester physicians is far in excess of the immediate inhabitants, since the clientele of the Clinic is world-wide. In point of fact, the same statement applies more or less to all large medical centers.

The most serious aspect of this movement of young physicians toward the large cities is that it is

steadily gaining force year by year. In those States distinguished for their large rural population, the proportion of doctors is growing less annually. In fact, in many of these States there are actually fewer doctors today than there were 20 years ago when the population was far

Number of Persons per Physician in the United States by Geographic Groups for Certain Years 1916 to 1936

Division and State	1936	1934	1931	1929	1927	1925	1923	1921	1918	1916
United States	778	785	793	797	791	781	764	744	709	694
New England States	678	682	708	720	715	709	716	695	668	652
Maine	883	851	809	785	767	756	729	699	648	630
New Hampshire	857	824	824	806	787	757	733	696	662	636
Vermont	755	723	721	723	676	663	638	595	541	529
Massachusetts	609	617	649	662	664	657	667	656	637	627
Rhode Island	737	751	822	853	854	842	839	792	791	754
Connecticut	723	735	762	791	786	797	844	818	788	766
Middle Atlantic States	651	671	710	728	745	754	751	740	714	697
New York	539	563	607	627	644	655	661	658	642	633
New Jersey	836	864	943	983	1013	1018	1029	1008	971	905
Pennsylvania	787	793	805	811	823	827	803	780	744	725
East North Central States	755	765	780	783	773	765	745	722	669	661
Ohio	754	764	776	781	773	769	750	728	693	671
Indiana	860	839	801	784	758	728	697	669	608	584
Illinois	672	677	678	680	672	661	642	625	573	580
Michigan	791	824	882	894	880	889	875	836	769	770
Wisconsin	859	881	954	976	986	990	987	973	918	901
West North Central States	809	804	790	779	760	747	726	710	668	662
Minnesota	803	825	838	827	844	879	882	918	912	930
Iowa	809	804	792	782	743	722	695	683	593	624
Missouri	721	694	646	639	625	607	597	580	559	526
North Dakota	1337	1364	1326	1354	1352	1371	1274	1177	1053	1061
South Dakota	1196	1163	1191	1171	1124	1104	1041	980	904	914
Nebraska	766	770	775	762	735	717	692	666	653	659
Kansas	848	855	871	846	806	774	725	700	659	649
South Atlantic States	971	968	923	907	895	888	859	841	831	806
Delaware	820	841	863	909	933	903	861	860	833	826
Maryland	614	635	663	669	663	669	644	624	629	608
District of Columbia	317	303	269	247	256	256	236	263	340	269
Virginia	977	979	940	959	954	935	938	914	890	872
West Virginia	1022	1012	981	969	949	916	888	875	811	796
North Carolina	1346	1372	1356	1327	1291	1266	1243	1185	1110	1157
South Carolina	1541	1480	1349	1331	1317	1301	1245	1165	1157	1160
Georgia	1236	1164	1007	997	990	930	886	851	828	816
Florida	847	862	855	809	747	852	845	813	722	674
East South Central States	1143	1106	1037	1002	970	928	880	836	769	748
Kentucky	1041	1000	917	895	862	830	787	738	688	662
Tennessee	1004	962	891	866	843	795	754	715	665	660
Alabama	1361	1317	1209	1163	1139	1098	1059	995	915	885
Mississippi	1294	1286	1293	1221	1161	1121	1041	1035	907	875
West South Central States	972	963	947	946	916	882	835	793	738	716
Arkansas	1059	1045	942	908	869	817	776	724	667	640
Louisiana	994	995	1024	1016	991	985	924	921	862	848
Oklahoma	1062	1034	976	973	935	882	828	794	738	719
Texas	909	904	913	925	900	872	830	779	728	703
Mountain States	791	821	831	846	829	801	757	733	714	698
Montana	1099	1106	1111	1075	1066	1034	960	897	790	765
Idaho	1183	1219	1164	1130	1101	1055	965	908	907	896
Wyoming	893	975	974	962	913	828	780	745	736	705
Colorado	551	565	550	571	560	540	517	525	536	513
New Mexico	1002	1023	1144	1141	1138	1080	957	863	779	810
Arizona	742	825	897	1042	1039	1028	991	918	943	936
Utah	950	987	1047	993	954	952	944	923	897	907
Nevada	671	705	702	693	677	637	586	540	491	513
Pacific States	582	599	631	639	630	616	618	613	610	592
Washington	802	811	822	842	834	824	813	772	779	755
Oregon	757	764	758	744	741	744	727	706	662	626
California	519	538	578	585	573	554	556	555	551	536

smaller. Furthermore, this movement is not at the expense of any particular section of the country; it is to be remarked wherever the rural population is extensive. In Maine, for example, the number of doctors today is 966, whereas in 1916 there were 1,205; in Iowa the respective figures are 3,146 as against 3,751; in Georgia they are 2,765 as against 3,421; in Kentucky, 2,770 as compared with 3,584, and in Montana, 483 as opposed to 636.

Of course, this does not mean, necessarily, that the populations of these States suffer from less medical service, today, than they had in 1916. The better roads movement, the increase and improvement in automobiles, the development of the airplane, together with the extension of modern hospital facilities to the rural regions, all enable the country doctor of today to attend to a much larger number of patients than was possible 20 years ago.

Nevertheless, it seems that many newly graduated physicians are missing opportunities by preferring to locate in the large cities where the medical profession already is much overcrowded, rather than in certain smaller communities where the need of up-to-date medical knowledge is acute.

Health Record for July 1936

THE effect of the country-wide heat wave of early July was reflected in unusually high mortality, for this period of the year, among the 17,000,000 wage-earners and their dependents who are Industrial policyholders of the Metropolitan Life Insurance Company. Their death rate for the month was 8.2 per 1,000, the highest July figure in five years. This marked an increase of 5.2 percent over the rate recorded in the same month of last year. A much greater rise (21.2 percent) occurred in the mortality in the general population of the large cities of the country.

The number of deaths charged directly to excessive heat is not an accurate measure of the effect of a protracted heat spell on the mortality rate. It is interesting to observe, for example, that out of 12,255 deaths of Metropolitan Industrial policyholders, from all causes combined, during July, there were only 251, or 2 percent, which were allocated to heat as the primary and determining cause of death. The high July death rate was due, in large part, to increases in deaths from certain diseases in which the high temperature of early July was an important contributory factor. For example, the heart disease rate for the month was 13.5 percent in excess of that for July a year ago, and the rate for cerebral hemorrhage was 8.3 percent higher. There were many more deaths from diarrheal diseases. Deaths from accidents and from automobile fatalities also increased appreciably.

Despite the somewhat unfavor-

able developments of July, the health record for the year, to date, is excellent. The cumulative death rate for all causes combined is only 9/10 of 1 percent above that for the like part of 1935 which, it must be remembered, was a record year for low mortality in this important cross-section of the population of the United States and Canada.

In Canada, where the Metropolitan has approximately 1,250,000 Industrial policyholders, the cumulative death rate for the January-July period (6.6 per 1,000) is identical with that registered for the corresponding period of 1935.

Nineteen thirty-six is making an unprecedented record for low mortality from a number of diseases, namely, tuberculosis, diseases of the maternal state, measles, whooping cough, and diphtheria. The cumulative death rate for tuberculosis has been reduced 5.2 percent since last year, and that for puerperal conditions, 13.3 percent. What has happened to bring about this important decline for the latter cannot be determined at this time, and no figures are available to show whether or not a considerable drop has also occurred among women in the general population of the country.

There has been a decrease of 4.7 percent in the year-to-date death rate for cancer. Unless there is a sizable rise in the mortality from this disease during the remainder of 1936, the crude cancer death rate for the current year will be the lowest in five years.

The diseases to register noteworthy increases over their 1935 death rates are cerebral hemorrhage, heart conditions (including coronary disease), and pneumonia.

The death rate in the general population of the large cities of the United States during July 1936 was 12.6 per 1,000 estimated population. This may be compared with death rates of 11.2 in June 1936 and 10.4 in July 1935. As compared with June, there was increased prevalence of poliomyelitis and typhoid fever; there were fewer cases of diphtheria, influenza, measles, scarlet fever, and smallpox. Comparison with July 1935 showed that influenza was the only communicable disease to show increased prevalence.

Reports from 46 States and the District of Columbia show a marked increase in poliomyelitis, namely, 431 cases during July, as against 106 in June. The principal focus of this year's outbreak was in the State of Alabama, where 192 cases were reported in July as compared with only 17 in the previous month. The disease is apparently spreading to the adjoining States of Tennessee and Mississippi. In Tennessee 60 cases were reported in July as against no cases in June, and, in Mississippi, there were 15 cases in July as against no cases in June.

The following table shows the mortality among Industrial policyholders for July 1936, June 1936, and July 1935, together with the cumulative rates for the first seven months of each year.

METROPOLITAN LIFE INSURANCE COMPANY

Death Rates per 100,000 for Principal Causes. Weekly Premium-Paying Business in Industrial Department. All Ages (Annual Basis).*

MONTHS OF JULY 1936, JUNE 1936, AND JULY 1935.

CAUSES OF DEATH	ANNUAL RATE PER 100,000 LIVES EXPOSED*				
	July 1936	June 1936	July 1935	Cumulative January-July	
				1936	1935
TOTAL—ALL CAUSES	815.0	808.4	774.5	893.3	885.3
Typhoid fever	.7	1.0	1.3	.6	.7
Measles	1.1	.8	2.2	1.4	3.8
Scarlet fever	1.7	2.3	2.2	2.8	3.5
Whooping cough	1.3	1.5	3.0	1.6	3.1
Diphtheria	1.0	1.9	1.4	1.8	1.9
Influenza	3.7	9.7	3.0	19.8	19.8
Tuberculosis (all forms)	52.5	57.5	57.5	56.1	59.2
Tuberculosis of respiratory system	46.4	51.0	50.3	49.6	53.2
Syphilis, locomotor ataxia, and general paralysis of the insane	12.0	10.9	10.2	12.2	11.5
Cancer (all forms)	87.7	87.3	93.3	90.9	95.4
Diabetes mellitus	19.1	25.0	20.6	26.0	25.7
Cerebral hemorrhage; apoplexy	61.0	56.2	56.3	65.8	63.5
Diseases of the heart†	158.5	148.4	139.6	171.3	167.7
Diseases of the coronary arteries	21.8	23.2	22.6	25.7	22.8
Angina pectoris	7.6	8.5	7.5	9.1	10.0
Pneumonia (all forms)	38.8	57.1	37.4	87.2	82.0
Diarrhea and enteritis	10.6	6.9	9.2	6.9	6.8
Appendicitis	13.9	12.0	9.9	11.2	11.5
Chronic nephritis (Bright's disease)	55.1	55.9	56.5	62.6	63.4
Puerperal state—total	7.2	7.4	7.8	7.8	9.0
Suicides	9.1	8.4	10.2	8.9	9.4
Homicides	5.7	4.6	6.1	4.8	5.7
Accidents—total	78.5	58.0	61.3	55.3	53.4
Automobile accidents	20.6	21.2	19.0	17.4	18.4
All other diseases and conditions	166.3	164.0	155.2	163.5	155.5

*The rates for 1936 are subject to slight correction, since they are based on provisional estimates of lives exposed to risk.

†Excludes pericarditis, acute endocarditis, and acute myocarditis.

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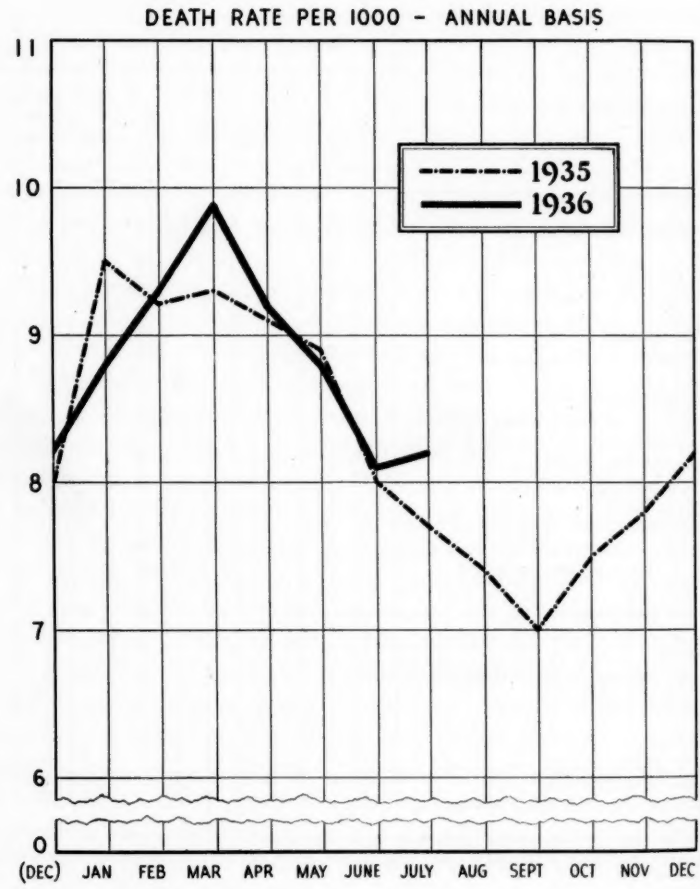
DEATH RATES FROM ALL CAUSES

METROPOLITAN LIFE INSURANCE CO. – INDUSTRIAL DEP'T.
WEEKLY PREMIUM-PAYING BUSINESS – TOTAL PERSONS



1935	9.5	9.2	9.3	9.1	8.9	8.0	7.7	7.4	7.0	7.5	7.8	8.2
1936	8.8	9.3	9.9	9.2	8.8	8.1	8.2					

Rates are provisional for 1936

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